to expect; but when the bone is much diseased, and surrounded by disorganized soft parts, the surgeon is more likely to attain, through his operation, an imperfect articulation, and one liable to inflame afresh under the influence of repeated pressure, and of movements of the limb. After resection, or after hip-joint disease, with prolonged suppuration, osseous or strong fibrous ankylosis is the most sure means of attaining radical cure, or at least a positive cessation of bad symptoms.—*London Medical Record*, Jan. 15, 1882.

Galvanism in Coxalgia.

M. Verneuil brought under the notice of the Paris Société de Chirurgie, at a meeting in October, an episode in the progress of coxalgia, which has not been sufficiently noted by writers on the subject, viz., a special form of recurrence of coxalgia after apparent cure. He gave the following as a type of this class of cases:—

Five years since, he saw, with M. Leudet of Rouen, a girl aged 9 who was attacked with coxalgia of a mild form at the outset, which M. Verneuil thought from its antecedents to be of a rheumatic character, and of which he made a favourable prognosis. The child was placed in a Bonnet's apparatus, which, shortly afterwards, was succeeded by Bouvier's trough. The cure was tedious; a small abscess formed outside the joint, and was cured in a fortnight. Fifteen months ago, that is to say, three years and a half after the appearance of the affection, M. Verneuil declared the child to be cured. Both limbs were of precisely the same length; there was not the least lumbar lordosis, and there was only a small remnant of stiffness in the joint. During this time, the girl had become considerably developed, and the menses had appeared. M. Verneuil, therefore, announced that cure was complete. Shortly afterwards, the father of the girl came to tell him that she limped, and in six months the patient was again under his charge. There was, again, considerable deformity, very marked lumbar lordosis; apparent shortening was brought on by the drawing up of the pelvis, but there was neither swelling nor pain, nor any trace of inflammatory action. The faulty position was reproduced without any trace of inflammation. Several surgeons having persuaded the father not to proceed further, and persisting in declaring the child to be cured, although the deformity continued to increase, she was again brought to M. Verneuil. He sought for something in the case analogous to the mechanism of flexion consecutive on inflammation of the knee by paralysis of the triceps, and discovered that the muscles of the nates were completely paralyzed. He thought, therefore, that the deformity was reproduced by the contraction of the psoas, the adductors, and the sartorius muscle. Under anæsthesia, by chloroform, he corrected the faulty position; the straightening was perfect, and there was complete symmetry. He again placed the girl in one of Bonnet's troughs; a month afterwards he applied Bouvier's apparatus, ordering that it should have a lengthened trial; and also ordered faradization of the gluteal muscles; but it was a very long time before any good results followed this treatment.

The latter fact gave to M. Verneuil the explanation of many others; the case was one of recurrence of deformity without return of inflammation of the joint; of muscles consecutively rendered powerless, whilst the antagonistic muscles retained their contractility. These facts led M. Verneuil to find in the muscular system a physiological explanation of the two periods of coxalgia. In the first stage, there are abduction, rotation outwards, evident lengthening, and permanent flexion. In the second stage, there are, on the contrary, abduction, rotation inwards, and shortening by the raising of the pelvis. These observations led M.

Verneuil to form the following theory: The inflammation of the joint is propagated to the muscles immediately in relation with the capsule, that is to say, to the psoas and the small gluteal muscles, leading to elongation of the limb with abduction. After a time these muscles become atrophied and lose their power; the inflammation spreads to the most distant muscles, that is to say, to the abductors and the sartorius; then come rotation inwards, shortening by elevation of the pelvis, that is to say, metamorphosis of position in the first stage of coxalgia; in the second period, slow contraction of the healthy muscles at the same time with the impotence of the muscles originally attacked. An important therapeutical indication is deducible from this fact, that of galvanization of the enfeebled muscles.—*London Med. Record*, Dec. 15, 1881.

Isolated Disease of the Semilunar Fibroid Cartilages in the Knee-Joint.

In a recent paper with reports of cases (*Centralb. für Chir.*, Nos. 44, 45, 1881) Professor KOCHER of Berne, after a reference to the views of Volkmann on the important part played in fungous articular disease by primary circumscribed deposits in bone, states that other structures of a joint may be the seats of isolated disease, resulting after a time in general articular disorganization. Three instances are recorded from the author's practice of circumscribed fungous disease of the internal meniscus of the knee, which disease he would call meniscitis fungosa. In one of these cases, the subject of which was a man, aged 65, the disease had lasted for nearly nine months, and had obstinately resisted treatment. Shortly before the case came under the author's notice, there had been swelling of the knee from serous effusion. This patient was cured after the application over the swollen and tender meniscus of the actual cautery. In the two other cases, one patient being twenty-one, the other six years of age, there was not only intra-articular effusion, but the disease had gone on to suppuration and the formation of sinuses. In each of these cases, the diseased meniscus was excised with very good result, and the patient recovered, with free movement of the affected knee. The diagnosis of diseased meniscus in the knee seems to be attended with some difficulty. In Professor Kocher's cases, the most marked swelling and tenderness were by no means circumscribed in correspondence with the margin of the affected cartilage. Before incision into the joint, the internal condyle of the femur in one case, and the head of the tibia in a second case, were thought to be the main seats of the disease. The two cases in which a meniscus was removed prove, it is stated, that the removal of one of these structures impairs so slightly the functions of the knee, that the patient is subsequently able to extend his leg forcibly and to bend it at a right angle to the thigh. A fourth case is reported, of thickening of the external meniscus of the left knee in a lad aged fifteen, through chronic inflammation of the joint. This enlarged meniscus presented complete extension, interfered with flexion, and caused a loud crepitus. Excision of this structure was followed, after healing by primary intention, by very good functional results. This case proves that the external meniscus may be removed without any consequent impairment of the functions of the knee-joint. In this, as in the cases of removal of the internal meniscus, the leg could not be carried beyond the ordinary degree of extension, and so the cases have some physiological interest by showing that the menisci do not act as checks in extreme extension of the lower limb. In concluding this paper, Professor Kocher reports a case of advanced disease of the knee, in which recovery with a movable limb followed arthrotomy and extension of the diseased and ulcerated portions of articular cartilage.—*London Med. Record*, Jan. 15, 1882.